DATE: 04/25/14

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 04/25/14

IRO CASE #:

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Radiofrequency ablation of the medial branch nerves on the left at L4-L5 and L5-S1

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

_____ Upheld (Agree)

__X__ Overturned (Disagree)

_____ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
724.2 *724.2* *724.2* *724.2*	*64635* *64636* *77003* *99144*		*Prosp.* *Prosp.* *Prosp.* *Prosp.*				*Xx/xx/xx* *Xx/xx/xx* *Xx/xx/xx* *Xx/xx/xx*		*Overturned* *Overturned* *Overturned* *Overturned*

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):
This gentleman was injured on xx/xx/xx. There is persistent back pain. An MRI scan on 08/13/10 revealed a left paramedian and central herniation at L5-S1, and epidural steroid injection was performed in 2010. Radiofrequency ablation was performed on the right at L4-L5 and L5-S1 on 07/24/12 and on the left in November 2012. The right radiofrequency was repeated on 12/30/13. Prior denial was based on the opinion that radicular pain was present, which did not meet Official Disability Guidelines criteria for radiofrequency ablation.

In a 03/26/14 office visit, it is stated that the claimant received 90% pain relief for five plus months after the last radiofrequency procedure on the left and that he is "not feeling pain going down the leg or buttock." Medications included ibuprofen and hydrocodone, and a home exercise program was in place.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

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Elgin, TX 78621-0787
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Medical necessity has been demonstrated for the requested procedure. ODG endorses repeating a radiofrequency ablation if there is greater than 50% pain relief along with increased activity levels. The additional documentation fulfills that criteria and describes that no radiculopathy is present. Therefore, the criteria are met for the requested radiofrequency ablation.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

_____ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase
_____AHCPR-Agency for Healthcare Research & Quality Guidelines
_____DWC-Division of Workers' Compensation Policies or Guidelines
_____European Guidelines for Management of Chronic Low Back Pain
_____Interqual Criteria
_____Medical judgment, clinical experience and expertise in accordance with accepted medical Standards
_____Mercy Center Consensus Conference Guidelines
_____Milliman Care Guidelines
_X___ODG-Office Disability Guidelines & Treatment Guidelines
_____Pressley Reed, The Medical Disability Advisor
_____Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters
_____Texas TACADA Guidelines
_____TMF Screening Criteria Manual
_____Peer-reviewed, nationally accepted medical literature (Provide a Description):
_____Other evidence-based, scientifically valid, outcome-focused guidelines (Provide a Description)

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